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# Asset Building: One Way the ACA May Improve Health and Employment Outcomes for People With Disabilities

**Jean P. Hall, PhD[1,2], Noelle K. Kurth, MS[1], and Ellen P. Averett, PhD, MHSA[2]**

## Abstract

Working-age individuals with disabilities are often forced to live in poverty to maintain Medicaid coverage. This study explored the relationship between having assets in excess of usual Medicaid limits and health and quality of life in a sample of Medicaid Buy-In participants. Using self-reported survey data, we compared groups with US$2,000 or less in cash assets (the usual Medicaid limit) and those with more than US$2,000. Participants with higher assets had significantly better health status and quality of life. Males, younger respondents, and respondents with intellectual disabilities were most likely to have higher assets. Although many Buy-Ins allow assets greater than US$2,000, assets are still capped for most individuals. The Affordable Care Act's Medicaid expansion does not limit assets in determining eligibility. Especially for younger individuals with disabilities, expansion coverage might allow greater asset accumulation and better health and quality of life, while avoiding lifelong dependence on disability programs.

## Keywords

health care, Medicare/Medicaid, employment, policy

Working-age individuals with disabilities are often forced to live in poverty or near-poverty to maintain eligibility for health insurance through Medicaid. Medicaid Buy-In (MBI) programs operating in 45 states have provided an option for these individuals to work and earn more and, sometimes, accumulate cash assets in excess of the usual Medicaid limit of US$2,000 (Hall, Fox, & Fall, 2010; Hall, Kurth, & Hunt, 2013; Kehn, 2013). Nevertheless, most MBI programs still impose caps of various amounts on assets and require a Social Security disability determination as part of the eligibility process. Moreover, most of the almost 200,000 enrollees in MBI programs still work below the substantial gainful activity (SGA) limit imposed by Social Security Disability Insurance (SSDI) rules, thus having incomes generally well below 138% of the federal poverty level (FPL; national average annual earned income in 2011 was US$9,135; Kehn, 2013).

Past research has found that people with disabilities often apply for Social Security disability cash assistance programs such as SSDI and Supplemental Security Income (SSI) not for the income support, but for the associated eligibility for Medicare and/or Medicaid coverage (Chapman, Hall, & Moore, 2013); this phenomenon has been described as "health insurance motivated disability enrollment" (HIMDE; Kennedy & Blodgett, 2012). Once such eligibility is attained, beneficiaries may be reluctant to increase earnings and assets and thereby threaten continued health coverage (Levy, Bruen, & Ku, 2013). However, the Medicaid expansion under the Affordable Care Act (ACA) may change the options for this population by making Medicaid available to individuals with low incomes (below 138% FPL) regardless of Social Security disability status and asset levels (Jost, 2014). Enrolling in expansion coverage may be financially advantageous for people with disabilities in allowing them to accumulate assets above the usual Medicaid limit. Accumulation of assets, in turn, may translate to better quality of life and health status over time. With this fact in mind, the objective of this study was to determine the relationship between having assets in excess of usual Medicaid limits and the health and quality of life of participants in a small and unique Medicaid program, the Kansas MBI, which allows asset accumulation of more than US$2,000. If asset accumulation is associated with better health and quality of life, then people with disabilities enrolling in Medicaid expansion coverage may decrease costs both for federal disability cash assistance programs, by decreasing application rates, and for Medicaid, by potentially reducing health care expenditures.

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**Table 1.** Relationship Between Participant Characteristics and Asset Levels.

| Characteristic | *n* | Participants with assets ≤ US$2, 000 (%) | Participants with assets > US$2,000 (%) | *p* value[a] |
|---|---|---|---|---|
| Gender | 441 | | | <.001 |
| Male | 183 | 77.0 | 23.0 | |
| Female | 258 | 90.7 | 9.3 | |
| Age | 441 | | | <.01 |
| <30 | 29 | 69.0 | 31.0 | |
| 30–45 | 116 | 81.0 | 19.0 | |
| >45 | 296 | 88.2 | 11.8 | |
| Race | 431 | | | .556 |
| White | 388 | 85.3 | 14.7 | |
| Non-White | 43 | 86.0 | 14.0 | |
| Ethnicity | 434 | | | .173 |
| Hispanic | 20 | 75.0 | 25.0 | |
| Non-Hispanic | 414 | 84.8 | 15.2 | |
| Disability type | 410 | | | .001 |
| Mental illness[b] | 154 | 84.4 | 15.6 | |
| Physical[c] | 101 | 93.1 | 6.9 | |
| Chronic illness[d] | 83 | 89.2 | 10.8 | |
| Intellectual[e] | 58 | 69.0 | 31.0 | |
| Sensory[f] | 14 | 85.7 | 14.3 | |
| Marital status | 432 | | | .157 |
| Married | 69 | 89.9 | 10.1 | |
| Single | 363 | 84.3 | 15.7 | |
| Education level | 437 | | | .455 |
| ≥high school graduate | 407 | 85.5 | 14.5 | |
| <high school | 30 | 83.3 | 16.7 | |

[a]Using chi-square. [b]Includes conditions such as schizophrenia, bipolar disorder, and depression. [c]Includes conditions such as paraplegia, spina bifida, amputations, and traumatic brain injury. [d]Includes conditions such as end-stage renal disease, lupus, epilepsy, and cystic fibrosis. [e]Includes conditions such as Down syndrome, phenylketonuria, and autism. [f]Includes conditions such as hearing and visual impairments, deafness, and blindness.

## Method

### *Sample*

The study population included all enrollees in the Kansas MBI, also known as *Working Healthy*, as of March 2012 who had been enrolled at least 3 consecutive months ($n$ = 1,245). The Kansas MBI limits eligibility to people between the ages of 16 and 64 with cash assets no greater than US$15,000. Participants must also (a) earn at least minimum wage, (b) pay payroll taxes, and (c) receive a Social Security disability determination. Of the 504 total survey respondents (return rate of 40%), 441 completed a series of questions about their assets. Of these individuals, 15%, or 66 people, reported having assets greater than US$2,000, defined as having at least this amount in a checking and/or savings account. Table 1 provides a summary of demographic characteristics of the sample responding to the asset questions. These demographics are generally comparable with those of the entire Kansas MBI population, which is 51% female, 91% White, 3.6% Hispanic, 14.3% married, and has an average age of 47.4 years; disability types are known only for survey responders.

Individuals completing surveys received US$10 prepaid gift cards as compensation for their time. The University of Kansas Human Subjects Committee, which is the University's federally recognized institutional review board, approved this study design as well as all informed consent documents and procedures.

### *Survey Instrument*

The survey contained items related to demographics, disability type, quality of life, health status, and employment (the survey instrument is described in more detail in Hall et al., 2013, and is available upon request from the authors). To measure quality of life, we included the 26 items from the *World Health Organization Quality of Life* instrument (WHOQOL-BREF). Although not a normed measure, the WHOQOL is internationally recognized and widely used as a reliable, valid, and short measure of quality of life (Skevington, Lotfy, & O'Connell, 2004), previously used in other studies of people with disabilities (Miller, Chan, Ferrin, Lin, & Chan, 2008). Our survey also included the Short Form-12 (SF-12) (Version 1), a normed scale derived

**Table 2.** Relationship Between Health, QOL Measures, and Participant Asset Levels.

| Measure | Participants with assets ≤ US$2k (%) | Participants with assets > US$2k (%) | *p* value | β[a] |
|---|---|---|---|---|
| PCS score (*n* = 423) | | | <.001 | .196 |
| ≤50 | 82.7 | 55.4 | | |
| >50 | 17.3 | 44.6 | | |
| MCS score (*n* = 423) | | | <.05 | .106 |
| ≤50 | 70.7 | 53.8 | | |
| > 50 | 29.3 | 46.2 | | |
| QOL[b] (*n* = 438) | | | <.001 | .184 |
| Very poor | 1.1 | — | | |
| Poor | 13.7 | 4.5 | | |
| Neither poor nor good | 27.45 | 13.6 | | |
| Good | 46.0 | 56.1 | | |
| Very good | 11.8 | 25.8 | | |

*Note.* A PCS or MCS score of 50 is the US national mean. QOL = quality of life; PCS = physical component summary of the SF-12; MCS = mental component summary of the SF-12.
[a]Using a linear regression model controlling for gender, race, ethnicity, age, and education level. [b]QOL measures are from the *World Health Organization QOL BREF* survey instrument.

from the SF-36. The SF-12 yields summary scores for physical health (Physical Component Summary [PCS]) and mental health (Mental Component Summary [MCS]). It comprises multiple subscales, ranging from 0 to 100, with population mean scores of 50 on both PCS and MCS (Ware, Kosinski, & Dewey, 2000). The SF-12 is recognized as a valid and reliable measure of overall health status (Gandek, Ware, Aaronson, & Apolone, 1998; Jenkinson et al., 1997; Salyers, Bosworth, Swanson, Lamb-Pagone, & Osher, 2000).

### *Analyses*

We explored differences in quality of life (WHOQOL-BREF) and health status (SF-12) between respondents with US$2,000 or less in cash assets (the usual Medicaid limit) and those with more than US$2,000 in cash assets, using chi-square tests and linear regression. In particular, we looked at the relationship between having PCS and MCS scores greater than 50 (the U.S. population mean) or better quality of life and having assets greater than US$2,000. We also examined which participants were most likely to have assets in excess of US$2,000, again using chi-square tests to determine any significant differences in asset status within demographic categories.

### *Limitations*

This study is limited to a single state and a relatively small, racially non-diverse sample of MBI enrollees. Therefore, the results are not intended to reflect the U.S. population with disabilities at large, but at least many enrollees in MBI programs across the country. In addition, the data are cross-sectional in nature and therefore do not include longitudinal trends. The study is also exploratory in nature and provides potential areas of investigation for future research, including why younger participants are more likely to have higher assets.

## Results

As shown in Table 2, survey respondents with assets greater than US$2,000 were significantly more likely to have PCS and MCS scores above the national average of 50, and to report better quality of life. Using a multiple linear regression analysis to control for gender, age, race (White/non-White), ethnicity (Hispanic/non-Hispanic), and high school graduation status, we found that having assets greater than US$2,000 was significantly associated with better quality of life: $R^2$ change = .032, β = .184, $p < .001$; overall model $R^2 = .045$, $p < .01$; as well as higher physical health status (PCS) scores: $R^2$ change = .036, β = .196, $p < .001$; overall model $R^2 = .168$, $p < .001$; and mental health status (MCS) scores: $R^2$ change = .011, β = .106, $p < .05$; overall model $R^2 = .031$, $p = .133$. These regression findings, in particular, indicate that having greater assets is independently associated with better quality of life and health after controlling for other socio-demographic and socio-economic factors.

As shown in Table 1, male participants, those below the age of 30, and participants with intellectual disabilities were significantly more likely to report having higher assets than other participants. Indeed, age had a significant, negative correlation with assets in excess of US$2,000. However, education, race/ethnicity, and length of enrollment in the Buy-In were not associated with different levels of assets in this sample. In addition, while those in the higher asset group had slightly higher average monthly earnings (US$181 vs. US$149), the difference in earnings was not

statistically significant, indicating that asset accumulation occurred independently of higher earnings levels.

## Discussion

Currently in the United States, 4 MBI programs limit cash assets to US$2,000 or less, 29 limit assets at another level, and 4 impose no limits (among those reported; Kehn, 2013). MBIs, however, are an optional eligibility group and in some states may not continue post-ACA. In Kansas, almost all MBI enrollees earn less than 138% of FPL; nationally, average annual earnings are also well below this threshold (US$9,135 in 2011; Kehn, 2013). Researchers speculate that one reason for the lower earnings is the so-called "cash cliff" built into the SSDI program, whereby beneficiaries lose all cash assistance once their earnings consistently exceed the SGA threshold, currently set at US$1,040 per month (Hall & Fox, 2004; Hall et al., 2010; Stapleton, O'Day, Livermore, & Imparato, 2006). The ACA does not change SSDI program rules, so individuals with severe disabilities who need the cash assistance will still face barriers to increased earnings.

The ACA Medicaid expansion, however, might be particularly beneficial for people with disabilities who cannot currently attain Medicaid eligibility, perhaps because they do not yet meet the Social Security definition of disability, or have assets above their state's limits, or are employed at even part-time levels. Especially for younger individuals who are already accumulating assets, coverage under the Medicaid expansion could divert them from dependence on federal disability benefits, thus saving decades of cash assistance for federal programs. For this diversion to occur, expansion coverage would need to be comprehensive enough to meet the needs of at least some people with disabilities—an important point that should be considered by state and federal Medicaid policy makers. For example, policy analysts and provider groups have raised concerns about the adequacy of coverage for habilitative services under the Medicaid expansion benchmark plans (Brown, 2014; Rosenbaum & Teitelbaum, 2013). Similarly, personal attendant services needed by some people with disabilities will likely not be covered by expansion plans (Kaiser Family Foundation [KFF], 2012).

Although other research has repeatedly found a relationship between income and health status among non-disabled adults (Adler et al., 2008; Marmot et al., 1991), our study indicates that for low-income individuals with disabilities, having assets above the usual Medicaid limit is associated with significantly better health status and quality of life. In open-ended survey comments, Kansas MBI participants related that having money in the bank allows them to

- deal with unexpected expenses such as car repairs/replacement or illnesses ("I do worry a lot about my car; it is a 1986 and so far I have save[d] $1,400 toward replacing it when the time comes");
- offset lower earnings months for those with seasonal employment ("I make very little over the summer months and wish I had more money saved up to allow me to support myself during this time"); and
- provide greater security against homelessness, which some have experienced in the past ("I don't want to be destitute again; living in poverty is one thing, I can deal with that, destitute is a whole other thing").

The greater financial security experienced by those with more assets may result in reduced stress and thus be reflected in their higher MCS scores.

Similarly, respondents indicate that having additional discretionary monies empowers them to take their medications as prescribed and participate in health promotion activities, such as weight loss programs, perhaps eventually resulting in better physical health scores. Public policy that allows low-income workers to access Medicaid coverage without limiting their assets thus seems to make good sense both for the individuals whose health and quality of life may improve and for the medical programs that provide them with coverage, which may incur lowered costs. Simply put, Medicaid expansion under the ACA provides a new pathway to insurance and increased self-sufficiency for people with disabilities. At the same time, expansion programs provide states with the potential for substantial savings in their adult disabled Medicaid programs and the federal government with the potential to save billions in disability cash assistance.

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### Authors' Note

The contents do not necessarily reflect the policy of the Department of Education, and the readers should not assume endorsement by the Federal Government.

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